

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/14/2013</b>
NAME OF PROVIDER OR SUPPLIER <b>SAINT ANNE NURSING AND REHABILITATION</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3540 NORTHEAST 110TH STREET SEATTLE, WA 98125</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 28239 DSHS Nursing Home Complaint Intake ID:2905527 Power Outage</p> <p>Investigated 11/14/2013</p> <p>This report is the result of a Fire and Life Safety complaint survey conducted at Saint Anne Nursing and Rehabilitation Center, 3540 NE 110th, Seattle, WA by a representative of the Washington State Fire Marshal's Office. The purpose of this survey is to confirm that the Emergency Power System functioned as planned and the staff followed emergency protocols.</p> <p>The following report is the result of an investigation through document review and staff interviews with the Administrator (by telephone 1405-1415) and LPN on 11/14/2013 (1715-1730 in person @ SNF).</p> <p>On Friday 11/08/2013 at approximately 1800, line power from Seattle City Light was dropped (by a blown breaker at the power substation servicing the SNF). The transfer switch for the EPS automatically started the generator and switched the power to the facility from line to emergency power.</p> <p>Seattle FD checked in with the facility to confirm that the EPS was working and Seattle City Light was contacted for updates. Line power was re-established around 2000 hours and the facility power system returned to normal.</p> <p>It is determined that the facility's EPS performed as designed; there were no injuries associated with this incident.</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Marta Smith*


*Adminstrator*

*11/14/13*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	<p>Continued From page 1</p> <p>The facility is found to be in compliance with the existing 2000 LSC.</p> <p>The Surveyor was:</p> <p>██████████ Deputy State Fire Marshal Life Safety Code Inspector 28239</p> <p>The Surveyor was from: Washington State Patrol Fire Protection Bureau 2803 156th Ave SE Bellevue, WA. 98007 Telephone: (425) 401-7731 FAX: (425) 401-7842</p> <p> ██████████ DSFM 28239</p>	K 000		